ANDERSEN

CMS The Medicare, Medicaid, and SCHIP Agency

Centers for Medicare and Medicaid Services

The Cost and Benefit of the Health Insurance Portability and Accountability Act (HIPAA): Did HIPAA's Insurance Reform Provisions Lead to Changes in the Health Insurance Market?

April 2002

APPENDICES

Executive Summary

Over the period of a year, the Andersen Team, comprised of Andersen and CGI (formerly IMRglobal-Orion) consultants, has been working for the Centers for Medicare and Medicaid Services' (CMS) Private Health Insurance Group (PHIG) to examine the costs and benefits of the Health Insurance Portability and Accountability Act (HIPAA), Title I. Specifically the team has looked at HIPAA's impact in five sample states selected by PHIG: Colorado, Illinois, Missouri, North Carolina and Texas.

Our first report delivered a picture of pre-HIPAA market conditions in which we described the small group and individual market reform laws enacted in each state prior to when HIPAA became law in 1997. Additionally, we presented 1994 through 1999 statistics on the insured and uninsured population based on various demographics such as employer size and health status.

Our second report presented information gathered from the various stakeholders of HIPAA including state insurance regulators and healthcare payers. We described what the sample states are doing to ensure the implementation of the benefit and eligibility provisions of HIPAA and the resulting impact on availability of coverage, premiums and costs in the individual, small group and large group healthcare markets. Additionally, we presented healthcare payer perspectives on the influence of mental health parity, minimum maternity stay, and breast reconstruction legislation on coverage and cost sharing arrangements for their health plans.

The scope of this project narrowed following our mid-year presentation to PHIG of the preliminary findings from the first two reports. To better address the specific areas of HIPAA's impact of interest to PHIG, the remaining project tasks were redefined as follows:

- Quantify the number of individuals positively impacted by HIPAA, including individuals with health problems and individuals either employed by small companies or with head of household employed by small companies.
- Determine if HIPAA's provisions have led to negative changes in the healthcare market in the areas of premium fluctuations, modifications to healthcare coverage, employer waiting periods, and job-lock due to healthcare portability issues.

Our third report addressed the first of the revised tasks and provided a quantification of the number of individuals positively impacted by HIPAA, including individuals with health problems and individuals working for small companies. The Andersen Team presented an actuarial estimate of the number of individuals, in each of the sample states and nationally, who would not have been covered had HIPAA and similar legislation not been enacted.

In this report we present our findings on whether HIPAA, which was intended to be a positive influence on healthcare portability and availability, has led to

negative changes in the healthcare market. Specifically, we addressed the areas of premium fluctuations, modifications to coverage, employer waiting periods and job-lock.

The Andersen Team's research into these issues, as defined in the revised statement of work, is based on the collection of information for each sample state from existing data sources and through interviews with health plans, Departments of Insurance, large employers and advocacy groups for small businesses as well as through human resource literature reviews and the National Association of Insurance Commissioners (NAIC). Included in this document is a section that provides a detailed description of the methods we used to collect information from these sources.

Based on our interviews with Departments of Insurance, health plans, employers, employer advocacy groups and our review of human resource literature, we are able to make the following conclusions:

- *The cost of healthcare has increased markedly in the last several years. Increases in the cost of health insurance have created financial pressures on insurers and employers to modify plans. In many cases, employers seeking to control costs initiate changes.*
- *It is very difficult to attribute premium increases and benefit plan modifications directly to HIPAA. However, they are more prevalent in the small group marketplace, which has been more directly impacted by HIPAA's guaranteed issue and pre-existing conditions limitations.*
- *Among the changes most commonly seen are increases in cost sharing features, such as deductibles and copays. The area of pharmaceutical coverage in particular has had increases in cost sharing.*
- *Some actions that could limit coverage for small groups include changes in insurer commission and companies leaving the small group market in response to rating restrictions.*
- *There does not appear to be a direct tie-in between HIPAA legislation and changes in waiting periods*
- *Although there is some evidence that there has been a reduction in job immobility, it is still not possible to quantify the direct impact of HIPAA on job-lock.*
- *Continuation of coverage provisions, combined with the portability provisions of HIPAA, have the potential to help alleviate job-lock. However, neither these provisions nor HIPAA adequately address affordability issues.*

The Andersen Team has not audited or otherwise validated any of the data sources and is therefore not responsible for the accuracy of the data supplied.

Section I: Fluctuations in Premiums

In its second report and mid-year presentation, the Andersen Team presented qualitative information collected from the health insurers we surveyed in each of the sample states regarding HIPAA's impact on healthcare premiums. Most health insurers agreed that HIPAA has had an indirect influence on premiums as the administrative costs of issuing certificates of creditable coverage and other additional regulatory requirements are passed on to insured members. However, there was no consensus regarding whether HIPAA has had a direct influence on premiums.

Some health insurers stated that HIPAA has had a direct influence on premiums because of increased claim costs. These increased costs are a result of the elimination of the actively-at-work provision and the guaranteed issue provisions that have caused a deterioration of the risk pool used to base medical premiums. However, most of the health insurers whom we contacted have not made explicit adjustments to premiums for HIPAA. This is because they are unable to segregate those groups that have applied for coverage solely as a result of the changes required by HIPAA from those groups that would have applied for coverage had HIPAA not been implemented.

Highlights

Based on our evaluation of numerical data and interviews with health plans, Departments of Insurance and employers, we have reached the following conclusions concerning premium changes resulting from HIPAA:

- The cost of healthcare has increased markedly in the last several years. While premiums have been increasing in that period, it is very difficult to attribute these changes directly to HIPAA.
- Premiums continue to increase at a faster rate for small groups than for large groups. It is possible that this is at least partly a result of HIPAA's guaranteed issue and pre-existing conditions provisions, which expand coverage primarily to small groups.
- State "small group reform" legislation, based on NAIC model legislation, restricts rate increases for small groups with adverse health conditions.
- There is no empirical evidence that claims are increasing at a faster rate for small groups than for large groups.

Section Detail

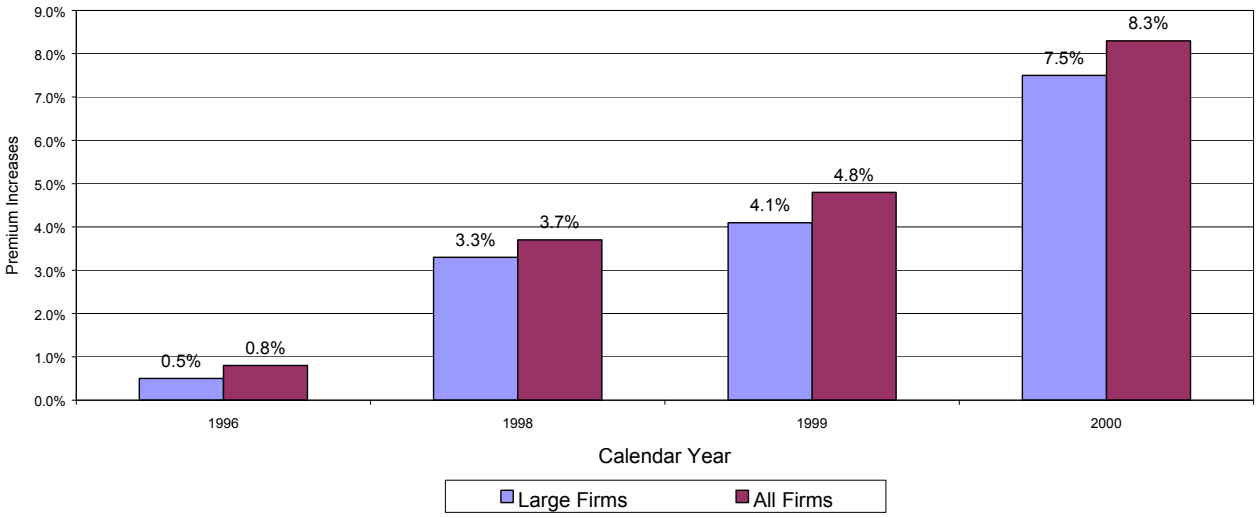
We researched additional data sources to enable us to draw quantitative conclusions regarding fluctuations in premiums since the implementation of HIPAA. We contacted the Departments of Insurance in each of the sample states.

We also contacted the National Association of Insurance Commissioners (NAIC), an organization that maintains a repository of annual statutory financial statements for insurance companies, to request annual statement information for the health insurers that we surveyed. Our primary sources for data concerning premium changes, however, were reports prepared by the Center for Studying Health Systems Change and by the Kaiser Family Foundation. We also interviewed health insurers and employers, to inquire about the impact of fluctuating healthcare premiums.

Premium Analysis

As we discussed in our second report, it appears from conversations with the largest healthcare payers in the five sample states that smaller groups are experiencing larger rate increases than groups as a whole, particularly in the most recent three years. In that same report, we presented a chart developed from a Center for Studying Health System Change data bulletin[1] which illustrates premium increases for all firms (including small businesses) have been greater than premium increases for "large firms" with over 200 employees, for the past several years. Presented below is information from that bulletin for the 1996 through 2000 time period.

Chart 1
Premium Increases
Large Firms v. All Firms



Note: Data for 1997 were not available.

[1] Center for Studying Health System Change, Tracking Health Care Costs: An Upswing in Premiums and Costs Underlying Health Insurance, Data Bulletin #20, November 2000, Figure 1, www.hschange.org

As shown in Chart 1, that rate of increase in premiums, between 1996 and 2000, for all firm sizes (including small businesses) is rising faster than for firms with over 200 workers. However, in our conversations with healthcare payers, the small employer groups were defined as firms with 49 or fewer workers and large employer groups were defined firms with 50 or more workers. Therefore, to verify the anecdotal data provided by health plans, we need to compare premium fluctuations for these firm size categories as defined by the health plans.

To further study the difference in premium increases between the large and small group healthcare markets, we expanded on the analysis presented by the Center for Studying Health System Change. Since their study was based on data from Kaiser Family Foundation reports[2], we obtained more specific and confirmatory data by extrapolating data from the Kaiser reports and applying actuarial estimation to determine premium increases for small firms (49 or fewer employees) and for large firms (50 or more employees). Table 3 below presents the results of our analysis.

Table 3: Analysis of Kaiser Family Foundation Reports

Percentage Increase in Premiums by Firm Size					
Firm Size (# workers)	**1996**	**1998**	**1999**	**2000**	**2001**
3 to 9	3.0%	8.0%	9.2%	8.4%	16.5%
10 to 24	2.2%	4.6%	6.9%	11.9%	14.4%
25 to 49	2.6%	6.1%	6.5%	7.7%	11.5%
50 to 199	0.7%	3.7%	5.5%	10.9%	10.8%
200 +	0.5%	3.3%	4.1%	7.5%	10.2%
Composite					
Small (3 to 49)	2.6%	6.4%	7.7%	9.7%	14.2%
Large (50 +)	0.5%	3.4%	4.4%	8.2%	10.3%
Difference	2.1%	3.0%	3.3%	1.5%	3.9%

Note: No Kaiser Report was identified for 1997.

As the bottom portion of Table 3 shows, small group premiums appear to be increasing at a faster rate than for large groups, with the exception of the year 2000. This provides some quantitative support to statements made by the health plans that small firms are experiencing increasing rates of premium changes than large groups. However there is not enough evidence to reach a definitive conclusion.

[2] Kaiser Family Foundation: Employer Health Benefits Annual Survey for 1999, 2000 and 2001 and Health Benefits of Small Employers in 1998; www.kff.org.

As another source for verifying the anecdotal information provided by the health insurers in the sample states, the Andersen Team requested 1996 through 2000 annual statement information from the NAIC for the healthcare payers we surveyed in our second report. Health insurers are required to file yearly statements that contain information on membership, premiums, claims and medical loss ratios.

Health insurers generally file annual statement information based on the rating method used for establishing premiums for their employer groups. Experience rated employer groups have their premium based in whole or in part upon the group's own claims experience. Large employer groups can be experience rated since the group's size is large enough for its claim experience to sufficiently predict future claims. Community and class rated employer groups have premiums based on the pooling of claims within the geographical community or industry class. Community and class rates are used mainly for smaller employer groups because employer groups lack the volume of claims history that can be used to predict future claim experience for that group.

We received annual statement information from the NAIC for 17 of the 25 health plans we contacted for our second report. We also received one additional statement for a health plan that later merged into another of the health plans we had surveyed as part of our second report. The breakout by rating method for these 18 plans is presented in the following table.

Table 4: Rating Methods Shown on NAIC Annual Statements

Rating Method	Number of Health Plans
Class or Community rated only	6
Experience rated only	1
Class/Community/Experience rated	7
Not defined	2
Suspect data	2
Total	**18**

The NAIC data was not as helpful as we had anticipated in quantifying health plan statements regarding premium increases. First, there were eight companies for which annual statement data was unavailable, which reduces the sample size for our analysis of the data. In addition, there were several companies for which data were not available for all years, which compromises the integrity of an analysis that compares changes between years. Of greater concern was the fact that of the seven plans that utilized more than one rating method, five of them combined the data for entire block of business to calculate a composite loss ratio. The health plans applied this composite loss ratio to back into the calculations of

premium and claim amounts for experience rated and community or class rated groups. In our interviews with the health plans, one actuary commented that this compositing of data is done in order not to reveal actual experience by block of business. However, for our analysis, this practice does not allow us to perform a valid comparison between experience rated and class or community rated groups.

The NAIC information does not provide a valid comparison between experience rated and class or community rated groups because the sample size for the experience rated category is too low. However, we are presenting our analysis of the small group premium information since it supports health plan statements that premiums in the small group market are rising.

The following table presents an actuarial analysis of the premium information from the credible annual statements received from the NAIC for class/community rated plans (small groups). To ensure the confidentiality of health plans, there will be no attribution of data to individual health plans. A description of the table elements and our analysis of the results follow the table.

Table 5: Analysis of Premium Data from Credible NAIC Annual Statements

	Small Group Class/Community Rated Plans		
Year	# of Plans w/ Data	Average Premium PMPM	Change in Premium PMPM
1996	7	1,310.05	
1997	7	1,411.66	7.8%
1998	8	1,475.67	4.5%
1999	8	1,550.34	5.1%
2000	7	1,742.28	12.4%
Annualized Change from 1996 to 2000			7.4%

In the above table, the Average Premium Per Member Per Month (PMPM) is a straight average of the PMPM premiums for each health plan. The Change in Premium PMPM is the percentage change between the current year's average premium PMPM and the prior year's average premium PMPM. The Annualized Change represents the constant yearly percentage change for the four-year time period and is determined using only the 1996 and 2000 information. For example, the formula for the annualized change in premiums is:

[(2000 Average Premium PMPM / 1996 Average Premium PMPM) ^ (1/4)] - 1

Within the small group market, the NAIC data show that overall premiums have increased between 1996 and 2000. As we presented in our second report, yearly increases in the medical component of the CPI have been consistently higher than yearly increases in the overall CPI for the past decade. Thus, these premium increases reflect more than general inflation increases.

According to a national small business advocacy group, the increase in premiums for small employers is a concern. The advocacy group stated that small employers are increasingly dropping coverage or increasing cost sharing levels with their employees in response to these premium increases. The advocacy group chapters within each sample state have said that employers are passing on a larger share of the premium costs to their employees each year.

Premium Rating Restrictions

Individual states are usually subject to premium rating restrictions set at the state level. Although HIPAA does not address issues of rating, state "small group reform" legislation usually does. In general, small group reform legislation, based on the Small Employer Health Insurance Availability Model Act, published by the NAIC, allows for "community rates" with variances for demographic features such as age, sex, family status, and location within the state. In four of the five sample states, insurers are permitted to increase or decrease rates by a given percentage based on anticipated claims experience of particular groups. The more insurers are permitted to vary rates for experience, the more difficult it will be for groups with adverse health risks to obtain coverage.

It is also likely to be less financial pressure on insurers if they are given great latitude in varying rates. The following is a state-by-state summary of small group rating restrictions.

- Colorado uses community rating. Colorado is the only one of our sample states that does not allow the use of anticipated claim experience in adjusting rates. Age, geographic location, and family status are the only criteria used in adjusting rates. In our discussions with Colorado health plans and the Colorado Department of Insurance, there have been comments concerning the financial pressures on small group insurers in Colorado, and the fact that many insurers have left the state.
- Illinois allows for demographic factors to be used in rating small groups. In addition, Illinois allows insurers to place groups in classes based on anticipated claims experience. These classes may be rated up or down a maximum of 25 percent from the midpoint.
- Missouri allows for demographic factors to be used in rating small groups. In addition, Missouri allows insurers to rate groups a maximum of 33 percent up or down from the midpoint based on anticipated claim experience
- North Carolina uses adjusted community rating with variances for age, gender, geographic location and family status. In addition, North Carolina allows insurers to rate groups a maximum of 20 percent up or down from the midpoint based on anticipated claim experience.
- Texas uses adjusted community rating with variances for age and gender. In addition, Texas allows insurers to rate groups a maximum of 20 percent up or down from the midpoint based on anticipated claim experience.

Note that although health insurance premiums are increasing more rapidly for small groups than for large groups, these increases would be more dramatic for some segments of the small group market if these rating restrictions were not in place.

Claims Analysis

In addition to an analysis of premium information, the Andersen Team also analyzed claim information from the annual statements. In an earlier report, we documented the causal effect of HIPAA's guaranteed issue provisions leading to increased claims resulting in increased premiums, as stated qualitatively by the health plans we surveyed. By also analyzing claim information, we can quantify increases in claim costs for large and small employer groups and determine if premium changes were independent of these claim increases.

The table below presents an actuarial analysis of the claim information from the NAIC annual statements that provide credible data for small groups. To ensure the confidentiality of health plans, there will be no attribution of data to individual health plans. A description of the table elements and our analysis of the results follow the table.

Table 6: Analysis of Claim Data from Credible NAIC Annual Statements

	Small Group Class/Community Rated Plans		
Year	# of Plans w/ Data	Average Claim PMPM	Change in Claim PMPM
1996	7	1,228.99	
1997	7	1,266.64	3.1%
1998	8	1,313.04	3.7%
1999	8	1,388.93	5.8%
2000	7	1,560.00	12.3%
Annualized Change from 1996 to 2000			6.1%

In the above table, the Average Claim Per Member Per Month (PMPM) is a straight average of the PMPM claims for each health plan. The Change in Claim PMPM is the percentage change between the current year's average claim PMPM and the prior year's average claim PMPM. The Annualized Change represents the constant yearly percentage change for the four-year time period and is determined using only the 1996 and 2000 information.

The above table shows that claim costs are increasing over time in the small group market, which has been anecdotally supported during our interviews with health plans and employers. From our review of the small sample size of NAIC

statement data for large groups, we see that the increase in claim costs is similar for both the large and small group markets. The lack of a significant difference in the increase does not support the degree of concern expressed by some of the health plans we interviewed regarding the impact of the guaranteed issue provisions of HIPAA on small group claims costs. A similar state level analysis in annualized rates of change in claims costs would provide more insight since some of the sample states had enacted guaranteed issue provisions prior to HIPAA. We did not perform this analysis because we did not receive a sufficient number of NAIC annual statements from any one of the sample states.

The claim cost increases through consecutive years in the study period confirm that claims costs are increasing over time in both markets, but at different times and rates. For large groups, claim cost increases were relatively small or nonexistent during 1996 through 1998, but then dramatically increased during the next two years. Small group claim cost increases are higher than for large groups during the 1996 through 1998 period, however, the increases during the next two years are not as significant when compared to large group claim increases.

A possible cause for the smaller increases in claims costs among small groups from 1999 to 2000 is the effect of "buy-downs", as reported by many of the health plan actuaries we interviewed. As small group rates continued to increase dramatically, many small groups increased cost sharing with their employees, thus lowering the increase for health plans in claims per member. Given the aforementioned concerns we have with the annual statement data obtained from the NAIC, we are unable to state this as a definitive cause. However, our discussions with the small business advocacy groups qualified the increased popularity in recent years of higher deductible plans with small employers.

Summary

In our second report, the Andersen Team stated that among the health plans we surveyed who said HIPAA had a direct effect on premiums, there was a consensus that HIPAA's impact on the large group market was not as significant as that on the small group market. The data sources we have researched support the conclusion of the health plans that premium increases in the small group market have been more substantial than increases in the large group market since 1996. However, all of the premium increases cannot be attributable to HIPAA since other factors such as benefit levels selected by employers, state healthcare reform, industry merger activity, healthcare inflation and general economic conditions are an influence on premiums.

Unfortunately, the small number of usable annual statements we received for inclusion in our analysis does not lead to results that can be applied across the healthcare industry in each state. Although we cannot make any strong conclusions about the impact of HIPAA or similar state legislation on premiums, we have been able to support more of the anecdotal and qualitative information provided from the health insurers we surveyed using the NAIC data and the reports

by the Center for Studying Health System Change and the Kaiser Family Foundation.

Our analysis also presents some interesting insight into the impacts of various factors, including HIPAA, on the small group and large group markets. Employers are responding to the changes in these markets by increasing cost sharing levels with their employees. Large employer groups are considering a change from fully insured status for health coverage to self-insured status. Small employer groups are trending towards either lowering levels of coverage to offset escalating premiums or dropping coverage all together when premiums become unaffordable. Additionally, health plans are modifying their approaches to benefit design as the demand for higher cost sharing plans increases. In some extreme cases, health plans are exiting the healthcare markets when they are unable to recoup higher claim costs.

Section II: Modifications to Health Coverage

In our discussions with health plans, Departments of Insurance and employers in each sample state, the Andersen Team has identified modifications in the approaches both health plans and employers are taking to benefit design. Specifically, we have attempted to determine if HIPAA's limitations on pre-existing condition exclusions have contributed to health insurers limiting benefit packages or altering the scope of coverage.

Highlights

Based on our evaluation of benefits literature and interviews with health plans, Departments of Insurance and employers, we have reached the following conclusions concerning benefit plan modifications resulting from HIPAA:

- Increases in the cost of health insurance have created financial pressures on insurers and employers to modify plans. In many cases, employers seeking to control costs initiate changes.
- It is very difficult to attribute these changes directly to HIPAA. However, they are more prevalent in the small group marketplace, which has been more directly impacted by HIPAA's guaranteed issue and pre-existing conditions limitations.
- Among the changes most commonly seen are increases in cost sharing features, such as deductibles and copays. The area of pharmaceutical coverage in particular has had increases in cost sharing levels.
- There have been some actions that could limit coverage opportunities. These include changes in insurer commission structure, which could reduce the incentive to market to small groups, and companies leaving the small group market in response to rating restrictions.

Section Detail

Overall, the changes being reported by health insurers are mostly attributed to general healthcare trends. These changes include "deliberalization" of policies (or weakening of benefits), including the elimination of certain benefit riders and increased cost sharing through higher deductible levels, copay amounts and decreased coinsurance levels. Of the 18 health plans we interviewed for this report, all but three have seen changes in benefit plans since the implementation of HIPAA. However, most plans that have seen changes cannot attribute them directly to HIPAA legislation.

The Andersen Team could not quantify the extent of these modifications to health coverage. However, our survey of large employers and interviews with small business advocacy groups verified anecdotal information received by the

health plans that they are modifying their approaches to benefit design as employer demand for higher cost sharing plans increases.

The descriptions of changes reported by the health plans and the supporting comments from the Departments of Insurance and employers in the sample states are presented below. Additionally, we present the other types of modifications to health plans or impacts of these modifications that were not reported by the health plans but described by either the Departments of Insurance or employers.

Limitations of Benefit Packages

The Andersen Team contacted the Department of Insurance (DOI) for each sample state in an effort to determine if the health coverage insurers offer has changed as a result of HIPAA's limitations on pre-existing condition exclusions. The DOIs in each of the sample states except Missouri did not report any specific violations by health plans related to benefit package design. Missouri's DOI was unable to comment since HIPAA health plan violations are not regulated by the DOI as Missouri is a direct enforcement state and the federal government monitors HIPAA compliance.

Colorado's DOI specifically stated that the guaranteed issue market has limited the number of products sold by small group carriers. Although Colorado small group carriers can offer other plans besides the two state required plans for small employers, the Colorado DOI has seen a post-HIPAA trend toward small group carriers only offering just the two required plans.

Several health plans have observed more changes in the small group market than in the large group market, especially in Colorado. One actuary for a Colorado health plan, who did not attribute changes to HIPAA, felt strongly that his state's community rating law, which does not allow premium adjustments for anticipated health variances, is driving costs up for small groups, leading to changes in coverage. His position is that, as insurers are unable to raise rates for only the groups with poor experience, rates are raised for all groups. The result is increased cost pressure on employers groups, which health plans attempt to relieve by weakening benefit plans through the deliberalizing of policies, such as the elimination of certain benefit riders.

Small business advocacy groups have confirmed that benefit plans are becoming more limited. The small businesses represented by the advocacy group have stated that choice of health benefits is one of their greatest concerns regarding healthcare, second only to increasing premium levels. It should be noted that the small business advocacy groups we interviewed are proponents of association health plans for small businesses, which would allow small businesses to better tailor packages that suit the benefit needs of their employees with the premium levels desired by the employer. The advocacy groups have expressed a high level of concern that health plans are offering less rich benefit plans with fewer choices in benefit structure and cost sharing levels (e.g. levels of deductibles, copay and co-insurance) for small employers.

The large employers we surveyed did not explicitly acknowledge experiencing significant benefit limitations with their health plans. It is likely that with a larger employee base and more significant buying power than small employers, the large employers are not as greatly impacted by benefit design changes.

Increased Cost Sharing

Another type of modification to benefit design experienced by health plans and employers includes increased levels of cost sharing through deductibles, copay amounts and coinsurance percentages. This type of modification is two-fold. First health plans are building greater levels of cost sharing into their products in response to the demand from employers, who are selecting greater cost sharing plans as a means to offset rising premiums.

The DOI in each sample state has described a trend among health plans in their respective states for increased cost sharing built into benefit plans. However, the Texas DOI stated that the changes in cost sharing arrangements are the result of healthcare trends and are not directly attributable to HIPAA. Instead, the Texas DOI's impression has been that these changes have been instigated by employers concerned with containing costs rather than by insurers.

As we have documented in our second report, the last several years have seen a sharp increase in the cost of healthcare, particularly in the pharmaceutical area. However, only one health plan has reported that HIPAA limitations are directly causing claim costs to increase and are leading to buy-downs in benefit packages, including increased cost sharing.

Most of the health plans we interviewed noted the trend toward building increased cost sharing into their health products. Several of the health plans noted utilizing procedure-specific cost sharing, higher cost sharing for pharmaceutical coverage, and coinsurance percentages where previously there had been 100 percent coverage. It was suggested by several health plans that health maintenance organizations (HMOs) may be less impacted than preferred provider organizations or indemnity plans because some states restrict cost sharing for HMOs.

According to the small business advocacy groups, small employers are increasingly selecting higher deductible plans for their employees. By selecting plans with higher cost sharing levels, small group employers can offset some of the premium increases with less rich health benefits for their employees. However, small business advocacy groups are seeing small employer groups trending towards either dropping coverage for dependents of employees or dropping coverage all together when the selection of higher cost sharing levels is not sufficient to lower the employer premium to affordable amounts.

The large employers responding to our survey all indicated they have selected benefits plans with greater cost sharing arrangements since the implementation of HIPAA. Changes in deductible amounts, copays and/or coinsurance levels were reported. One large employer specifically addressed having made changes in

pharmacy cost sharing arrangements within their selected employee health benefit plan.

Changes in Commission Structures

The Andersen Team asked the DOIs in each sample state what other problems or concerns had arisen since the implementation of HIPAA or HIPAA-like healthcare reforms in their states. Both the Illinois and Missouri DOIs stated that health plans have changed their broker commission structures so that it is not in interest of the broker or agent to pursue the smallest of the small employer groups. Although the reasons are not clearly evident, the Illinois DOI suggests the following as possible explanations for this health plan practice:

- Effort for health plans to build enrollee count more quickly by directing agent/broker attention to larger groups;
- Health plans believe that small employer group size is positively correlated with higher risk; and
- Health plans think the small groups are not as productive (for profits).

The national chapter of the small business advocacy group voiced a concern on this same issue; that health plans are discouraging enrollment in small group plans by cutting commissions for brokers and agents for groups under five employees.

Health Plans Exiting the Marketplace

In some extreme cases, health plans are exiting the healthcare markets when they are unable to recoup higher claim costs resulting from state or federal regulation. In Colorado, state rating restrictions are increasing financial pressure on health plans, which has led to the exit of several health plans, especially in rural areas.

Similarly, the burden of government restrictions, including mandated benefits, in North Carolina has caused many of the HMOs in that state to leave the healthcare market. The North Carolina small business advocacy group stated that small employers in that state who want to offer health coverage to their employees may not be able to afford even the basic plans due to the number of state mandated benefits. Overall, small employers in North Carolina are working with the health plans to select affordable plans for their employees, including higher cost sharing level benefits. However, if health plans are limited to rigid benefit designs due to these mandates, premium levels will remain out of reach for small employers, which could force more health plans out of the small group market.

More than half of the large employer groups responding to our survey indicated that one or more of their health carriers have exited their healthcare market since the implementation of HIPAA. However, none of these large employers stated they had difficulty finding a replacement health carrier.

The impact of health plans exiting the market may not be as great for large employers as for small employers. As has been noted by the health plans we interviewed, the impact of healthcare reform has been more significantly felt by health plans in small group markets compared to large group markets. As more health plans exit the small market, small employers will have increasing difficulty finding replacement health carriers and employees could continually be burdened with having to adjust to new provider networks.

Summary

Since the implementation of HIPAA, health plans and employers have been responding to the financial pressure of increased premiums by attempting to shift cost sharing arrangements. Employers unable to afford the rich benefit levels offered to employees in past years are seeking out higher cost sharing arrangements. In response, health plans are redesigning benefit packages to meet employer demand.

Among the modifications to health coverage most commonly seen are increases in cost sharing features, such as deductibles and copays, and reduced benefit packages. There have also been some actions on the part of health plans that could limit coverage opportunities, including changes in insurer commission structure and retreat from the small group market in response to rating restrictions.

Section III: Employer Waiting Periods for Coverage

The Andersen Team contacted DOIs, large employers and small employer advocacy groups in each sample state to determine if the provisions of HIPAA have resulted in increased employer waiting periods for health coverage for new employees. The waiting period is the duration of time, set by the employer, between an employee's date of hire and the date an employee becomes eligible for benefits under the employer's plan.

Highlights

Based on our review of human resource literature and interviews with health plans, Departments of Insurance, and employers, we have reached the following conclusions concerning changes in waiting periods resulting from HIPAA:

- Waiting periods appear to vary based on type of job, anticipated turnover, and general economic conditions.
- There does not appear to be a direct tie-in between HIPAA legislation and changes in waiting periods.

Section Detail

The Andersen Team contacted the DOI in each sample state to obtain information that would enable us to draw conclusions about changes in employer waiting periods. All of the DOIs stated that they do not collect information specific to employer waiting periods for coverage. However, each DOI stated qualitatively that they were not aware of complaints related to changes in waiting periods or that waiting periods for coverage were increasing in their state.

The information received from our contact with large employers and small business advocacy groups identified several factors that influence waiting periods for health coverage imposed by employers.

Economic Conditions

The small business advocacy group in Illinois attributed the observed recent increase in employer waiting periods for coverage more to general economic conditions than to the implementation of HIPAA. Six months to one year ago when the Illinois job market was tight, Illinois employers were having new employees wait up to six months for coverage since turnover was so high. In a 2000 survey of its employer members, Illinois employers stated that finding a qualified workforce is a high concern. Since longer waiting periods for coverage offset the administrative burdens for the employer of enrolling a new employee for

coverage, the employer is able to save on these costs when the employee leaves the job after a short period.

Employer Premium Levels

Small business advocacy groups could not specifically attribute the recent observed increases in employer waiting periods for coverage to the implementation of HIPAA. However, these groups have seen some relation between higher premiums in the small group market and increased employer waiting periods for coverage.

As a result of higher premiums in the small group market, small business advocacy groups have seen an increase in the popularity of short-term individual coverage. Workers subject to lengthened waiting periods for coverage from their small business employer are purchasing short-term individual coverage for themselves and dependents until they become eligible for their employer health benefits. Additionally, workers whose employers have dropped health coverage due to increased premium costs are regularly buying individual short-term coverage to meet their long-term needs, since it is less expensive than the cost of extended group benefits under state or federal continuation of coverage laws. Similarly, advocacy groups have observed an increase in the utilization of individual short-term health products for workers whose employers cannot afford coverage for their employees.

Industry Sector

Many of the DOIs commented that waiting periods are driven by the nature of the employer's industry. Therefore employees in industries that experience high turnover are generally subject to longer waiting periods for health coverage. This was confirmed through both our survey of large employers and our interviews with small business advocacy groups. Both large and small employers commonly impose longer waiting periods for health coverage for those employees filling positions that are subject to high turnover to, at a minimum, avoid the administrative costs of enrolling the employees for benefits.

Of the large employers we surveyed, those in the retail business indicated that they have 90-day waiting periods for their hourly employees, but shorter waiting periods, if any, for their management staff. Approximately half of the employees for these employers are accepting health coverage, which may indicate that a large portion of hourly employees, who are most subject to high turnover, are not remaining employed beyond the 90-day period required to obtain health coverage through their employer.

Similarly, small business advocacy groups stated that those employers in certain industries known for high turnover (i.e. seasonal businesses) were

attempting to offset the administrative costs of enrolling employees for health benefits through extended waiting periods for coverage.

Summary

There does not appear to be a direct relation between HIPAA legislation and changes in waiting periods. Waiting periods appear to vary based on type of job, anticipated turnover, and general economic conditions. In response to high premiums, some employers may apply waiting periods to avoid costs of enrolling short-term employees in high-turnover jobs, usually positions paid on an hourly basis or seasonal jobs. However, this practice is not a direct result of HIPAA legislation.

Section IV: Job-Lock due to Healthcare Portability Issues

In its second report, the Andersen Team stated that the DOI for each sample state and the health plans surveyed agreed that HIPAA has helped to reduce the problem of lost health coverage for those individuals who would have been subject to coverage limitations by changing jobs. However, DOIs and health plans were unable to quantify the reduction in job-lock (job immobility due to health benefits) for employees resulting from the previous non-portability of health coverage.

Highlights

Based on our analysis of human resource literature and interviews with employers and employers' advocacy groups, we have reached the following conclusions concerning changes in job-lock resulting from HIPAA:

- Although there is some evidence that there has been a reduction in job immobility, it is still not possible to quantify the direct impact of HIPAA on job-lock.
- Based on a report prepared by the Employee Benefits Research Institute, there appears to be a reduction in job immobility attributable to health status from 1998 to 2001.
- Continuation of coverage provisions, combined with the portability provisions of HIPAA, have the potential to help alleviate job-lock. However, neither these provisions nor HIPAA adequately address affordability issues.

Section Detail

To identify statistics that would enable us to reach a definitive conclusion on the issue of job-lock in each of the sample states, we analyzed Human Resource literature, contacted the benefit departments of major employers and contacted small business advocacy groups. Specifically, we attempted to identify information that could be used to quantify employee activities related to health benefits, including the following:

- Voluntary turnover rates prior to and post-HIPAA;
- State continuation of coverage laws that could affect employee job-lock;
- Health insurance coverage for part-time workers vs. full-time workers;
- Individuals switching from part-time work to full-time work because of a lack of insurance; and

- Productivity rates and higher relocation and training costs for long-time workers bound to their employee health coverage because of medical conditions.

Additionally, the Andersen Team has attempted to determine from large and small businesses the extent that portability provisions changes have affected job immobility due to health benefits among workers. In our discussions with small business advocacy groups, the individual chapters of each sample state were unable to comment on the specific impact of HIPAA on the alleviation of job-lock, other than to state that it has been difficult to separate HIPAA's impact from that of the economy in general. Overall, from the national perspective, small business advocacy groups stated that job-lock was less of an issue for small business owners since they choose to work in their own businesses for the flexibility and not for the health coverage. However, the advocacy groups recognized that the larger the size of the small business the more likely job-lock is to be of concern since health benefits are used as a recruiting tool. Our surveys of large employers confirmed the use of health benefits as a recruiting tool and offered additional insight that is presented throughout this section.

The following is a summary of the Andersen Team's efforts to identify job-lock statistics on the areas listed above, the job-lock statistics obtained and a discussion of considerations when interpreting these statistics.

Job-Lock Statistics and Interpretation

Overall, the Andersen Team was not able to identify statistics that would allow us to quantify the number of individuals who experienced job-lock due to portability issues since there is a scarcity of data available providing a direct link to health insurance coverage and job-lock. Even current employee turnover data is more influenced by changing economic conditions than by insurance issues and therefore cannot directly be applied to the issue of job immobility related to health benefits.

Although we identified several statistics that relate to the issue of job-lock, from our review of the human resource literature and related job-lock research papers, we have determined that the interpretation of job-lock statistics must consider the underlying population on which the statistics are based. An individual's perception of job immobility depends on a variety of factors, each of which may be valued differently by another individual. Among these factors are health status, gender, marital status, income level, job tenure and current insurance status and/or spousal insurance status.

The measurement of job-lock is also affected by other factors outside of the individual's influence, such as state and federal regulations (i.e. continuation of coverage laws) and health insurer practices (i.e. premium levels). To accurately interpret a statistic on job-lock, one must consider the impact these factors play in the outcome being measured.

The Andersen Team was not able to identify job-lock studies that specifically measured job immobility due to health benefits for the various segments of the population that similarly value the factors that influence the perception of job immobility. However, we were able to identify some data that provide valuable insight into the issue of job-lock. Throughout this section, we have included information collected from large employers pertaining to employee activities related to health benefits that should be considered when analyzing statistics on job-lock.

Voluntary Turnover Statistics

Voluntary separations are employee-initiated terminations such as resignation, retirement, disability and death. Involuntary separations include termination of employment initiated by the employer, such as layoffs or disciplinary actions. Employee deaths are included as part of voluntary turnover statistics more to categorize the event as employee initiated rather than employer initiated.

A study of the resignation rate within voluntary separation data would provide insight into employee willingness to change employers. The other components of voluntary separation, where an employee leaves an employer but does not resume employment (retirement, disability and death), are not related to job immobility due to health benefits.

Our research revealed that employee turnover rate data are commonly consolidated and do not distinguish between involuntary and voluntary separations. However, we were able to identify a report prepared by the Society for Human Resource Management (SHRM), which discusses voluntary resignations in recent years. The survey reports findings of retention practices among approximately 500 human resource professionals during the year 2000 and makes the following conclusions:

- 41 percent of survey respondents indicated an increase in the number of voluntary resignations in the past three years.[3]
- Of the survey respondents, 50 percent of large employers with 1,000 or more employees, and 39 percent of employers with fewer than 1,000 employees reported that voluntary employee turnover has increased during the previous three-year period.[4]

Human resource professionals are citing better compensation and benefits packages offered by other employers as one of the largest threats to employee retention.[5] Healthcare benefits received the highest ranking by human resource professionals as the most effective tool for retaining employees.[6]

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[3] Society for Human Resource Management, "Retention Practices Survey", 2000, Page 7.
[4] Ibid.
[5] Ibid., Page 8.
[6] Ibid., Page 12.

Although the SHRM survey indicates that voluntary resignation rates are on the rise, careful interpretation of the factors behind this implied alleviation of job-lock must be made. For example, are employees feeling less locked into their current job since compensation levels are increasing due to favorable economic conditions?

Through our survey of large employers, we attempted to determine if there have been similar trends in voluntary resignation rates and employee satisfaction with employer health coverage among large employers. Most employers who responded to this set of questions did not report any change, between pre- and post-HIPAA years, in the reasons why employees left their place of employment. Additionally, of those employers stating that they calculated voluntary turnover statistics, none said that these statistics showed that portability laws were alleviating the problem of job-lock. However, our sample size of employers responding to the survey was small, as noted in an earlier section, and it is possible that a broader survey would have revealed information to the contrary.

Job Immobility Statistics

The Andersen Team's research attempted to find job-lock statistics from the same source to identify trends in job immobility. We identified survey questions sponsored by the Employee Benefit Research Institute (EBRI) that specifically addressed the issue of job immobility due to health benefits.

In EBRI's Health Confidence Survey for the years 1998 and 2001, two questions specifically addressed the issue of the relation between job mobility and employer-provided health coverage. These exact two questions were not asked in any other survey years. In the surveys for each of these two years, approximately 1,000 individuals responded to the following two questions related to job-lock:

- *Have you, or an immediate family member, ever passed up another job opportunity, stayed at a job you would have quit otherwise, or not retired only because you needed to keep the health insurance coverage you were receiving?*

- *Which of the following best describes the reason you or your family member stayed?*
  - *(a) Potential employer did not offer health insurance*
  - *(b) Potential employer offered fewer benefits than you had*
  - *(c) You or a family member had a medical condition that would not be covered by a potential employer's health plan*
  - *(d) The potential employer's health plan cost too much*
  - *(e) You could not afford health insurance on your own*

The results from these survey questions are included in following table.

Table 7: EBRI Health Confidence Survey Results

	1998	2001
Job immobility due to health benefits	Yes - 27%	Yes - 21%
Reason:		
(a)	15%	15%
(b)	26%	20%
(c)	14%	18%
(d)	7%	6%
(e)	30%	28%
(f)	8%	13%

The survey results show that the percentage of survey respondents experiencing health benefit related job immobility has decreased between 1998 and 2001. An analysis of the underlying population does not reveal a significant difference in respondents by factors such as gender, income level or work status (working versus retired).

The most common reason stated for experiencing job immobility is based on job-lock as it has been defined for this project, i.e. lost or reduced coverage. In both survey years, there is a high percentage of people who fear losing coverage (Reason A) or reducing coverage (Reason B) by accepting a job with a potential employer. The second most common reason survey participants experience job-lock is related to affordability of health coverage when employer-sponsored insurance is not provided (Reason E).

Additionally, the reasons provided for job immobility have shifted between 1998 and 2001. Fewer individuals are reporting the potential employer's coverage at reduced levels from existing employer coverage as a restriction to job mobility. However, more individuals are attributing job immobility to a medical condition that would not be covered by a potential employer's health plan, which could be attributed to an individual's lack of understanding about the HIPAA's limitations on pre-existing condition exclusions.

State Continuation of Coverage Laws

Laws extending group health coverage, for a temporary period, to an individual leaving a job will increase voluntary job mobility when immobility is based on the fear of losing healthcare coverage. This temporary period of continued coverage is generally sufficient for the employee to obtain new employment with employer-sponsored health insurance.

In 1985, the federal Consolidated Omnibus Reconciliation Act (COBRA) continued group coverage for qualifying individuals for up to 18 months or longer depending on the "qualifying event" leading to terminated health benefits.

COBRA applies only to employers with more than 20 employees. Individuals continuing their coverage under this law pay more than the full premium charged by the health plan to the employer to compensate for adverse selection against the health plan.

State continuation of coverage laws extend coverage in a similar manner to the federal law. Prior to COBRA, certain states passed their own continuation of coverage laws. State continuation of coverage laws generally fill in gaps in COBRA. For example, they apply to firms with fewer than 20 employees and do not allow coverage to be denied to employees who have been terminated for gross misconduct, as COBRA does. Continuation of coverage laws are generally for a shorter term than COBRA. HIPAA augments the federal continuation of coverage law by mandating that health insurers not refuse to offer coverage to individuals whose extended period for coverage under COBRA has elapsed. The combination of continuation of coverage laws with the portability provisions of HIPAA should serve to increase voluntary mobility and reduce job-lock. However, continuation of coverage laws do not address affordability issues for workers who must pay more than the full premium charged to their former employer to continue coverage. Workers whose employer contributes a full or partial payment for the cost of healthcare may find themselves experiencing job immobility despite federal and state continuation laws.

The Andersen Team was not able to identify statistics related to continuation of coverage laws and their impact on job immobility due to health benefits.

Full-time versus Part-time Status

Whether a worker is full-time versus part-time plays a major role in whether they receive health insurance from their employer. According to the Bureau of Labor Statistics, two-thirds of full-time workers receive employer-sponsored coverage whereas only one-fifth of part-time workers receive employer-sponsored coverage.[7]

Since part-time employees generally do not receive health coverage from their employer, these workers are less likely to experience job immobility due to health benefits than their full-time counterparts. When interpreting the results of a job-lock study, consideration needs to be given to the work status of the underlying population.

The Andersen Team attempted to determine the differences in health insurance coverage for part-time and full-time workers and if any discrepancies in coverage levels have been an impetus for part-time workers to switch to full-time status. All of the employers responding to the survey reported employing part-time staff. However, less than half of these employers reported differences in health insurance coverage levels between full-time and part-time staff. Although employers could not determine if part-time workers were switching to full-time work to gain additional health benefits, most stated that they provide other benefits such as flex

[7] Bureau of Labor Statistics, Monthly Labor Review, "Earnings and Benefits of Contingent and Noncontingent Workers," 1996, Page 24.

time, telecommuting, parking and child-care as ways of encouraging full-time over part-time work.

Productivity Rates and Relocation/Training Costs

Job-lock plays a role in productivity and relocation/training costs for an employer. The concern for lost or decreased health insurance following a voluntary resignation from an employer may be enough to deter an unproductive worker, best suited for a different job, from leaving their current employer and seeking new employment. When the employee does eventually separate from employment (via retirement, disability or death), the training costs incurred by the employer to replace that employee may be higher than they otherwise would have been had the employee not experienced such job immobility.

Even prior to the implementation of HIPAA in 1997, the Jerome Levy Economics Institute noted the negative impacts of job-lock on employers and the economy in a 1993 policy brief:

> "…the nation pays an economic price in terms of the costs associated with the misallocation of workers among productive opportunities; higher relocation and training costs for those workers who have stayed too long in their jobs; and the loss of innovation, employment, and competition related to start-up ventures." [8]

As job-lock is alleviated, the economy should benefit as employee productivity rates rise and employers experience a decrease in unnecessary relocation and training costs.

To determine if employers were experiencing increased productivity rates due to an alleviation of job-lock, our survey of large employers inquired about practices for tracking productivity rates within employer organizations. Of the employers that did track such data, none were able to determine if there was a correlation between productivity and job-lock.

Summary

HIPAA does not appear to have directly resulted in an increased alleviation of job-lock due to health benefits. Although some studies show evidence that there has been a reduction in job immobility, it is still not possible to quantify the direct impact of HIPAA on job-lock. Since job-lock is based on individual perception, surveys that measure job-lock need to consider the impact of the factors that alter an individual's perception of job immobility when interpreting such statistics.

[8] The Jerome Levy Economics Institute of Bard College, "Job-Lock: An Impediment to labor Mobility: Is Health Insurance Crippling the Labor Market?", Summary Page 1.

Section IV: Information Sources

The Andersen Team has compiled information through interviews with health plans, Departments of Insurance and large employers in each of the sample states, as well as from advocacy groups for small businesses, human resource literature reviews, and the National Association of Insurance Commissioners (NAIC).

Departments of Insurance

Our Departments of Insurance (DOI) contacts for each sample state were established during our research for the first two project reports. We conducted additional phone interviews with representatives from each department. The questions that were asked during the interview are included in Appendix 1. Our contacts within each state's DOI are included in Appendix 6.

Healthcare Payers

Our health plan contacts were established during research for our second report. We again contacted the chief actuaries of the major health insurers in each of the sample states to further discuss HIPAA's impact on their health plans. We asked a series of questions that are contained in Appendix 2. To encourage health plan participation, confidentiality of health plan names was assured and no attribution of responses to individual health plans will be made in our report.

Of the 25 health plans we surveyed for our second report, we received responses from 17. For this report we contacted those health plans and received comments from 18 of those plans. The participation of these health plans at the state level is presented in the following table.

Table 1: Health Plan Participation

State	Health Plans Contacted for Previous Report	Responses Received for Previous Report	Participating Health Plans for Current Report
Colorado	5	4	5
Illinois	7	4	3
Missouri	4	3	3
North Carolina	5	2	3
Texas	4	4	4
Total	**25**	**17**	**18**

Large Employers

The Andersen Team identified the four largest employers in each sample state through lists provided by each state's Departments of Labor. Using this list, we identified contacts within each employer's benefit/employee relationship departments. Surveys were distributed to contacts made in those offices. Our survey included questions related to HIPAA's influence on employer sponsored health coverage, health plan changes and job-lock. The questions were designed to determine HIPAA's impact on employer waiting periods for coverage, benefit packages offered by health plans and alleviation of job-lock.

The survey was sent in early September to the top four largest employers in each state. However, we were only able to obtain responses from eight of the 20 employers. Although the sample size of employers responding to the survey is small, the employer responses we did receive were sufficient, in most cases, to qualify anecdotal information provided by health plans and the DOIs.

To encourage employers to participate in our survey, confidentiality of employer names was assured and no attribution of responses to individual employers will be made in our report. The survey questions are included as part of Appendix 3.

Small Business Advocacy Groups

Recognizing that the impact of HIPAA may differ for large and small employer groups, we have also presented in our report the perspective of the small business. However, due to the large number of small employer groups in each of the sample states, we contacted small business advocacy groups. We determined these advocacy groups were an efficient approach to presenting a unified perspective for all small businesses in their respective states. Our contact with these advocacy groups was accomplished through phone interviews. A list of the questions posed to each advocacy group is in Appendix 4. To encourage participation, confidentiality of small employer names was assured and no attribution of responses to specific small employers will be made in this report.

Human Resource Literature

In an effort to identify trends in job-lock resulting from HIPAA, we performed a review of human resource literature. A list of the human resource organizations and articles reviewed is included in Appendix 5

National Association of Insurance Commissioners

We collected annual statement information from the NAIC for the health plans we contacted in each of the sample states. The NAIC maintains a repository of annual statutory financial statements for insurance companies. These statements

include information on total enrollment, premiums and claims. Data was collected for the years 1996 through 2000 to quantify anecdotal statements made by health plans in our second report.

The table below compares the number of health plans that were asked to participate in our second report with the number of health plans for which the NAIC had annual statement information available. Note that for several of these health plans the NAIC did not have statements for every year for which we requested. Also, there were eight health insurers for which annual statement information data were not available for any of the years that we requested.

Table 2: NAIC Annual Statements Received

State	Number of Health Plans for which Statements were Requested	Number of Health Plans for which Statements were Received
Colorado	5	3
Illinois	7	3
Missouri	4	2
North Carolina	5	5
Texas	4	5*
TOTAL	**25**	**18**

** Note: More statements received than requested due to merger activity.*

Report Summary

As we have illustrated in this and earlier reports, a number of factors influence the extent, cost, and quality of health insurance coverage. In addition to HIPAA, these factors include: general economic conditions, health cost trends, and state legislative initiatives among others. As such, it is difficult to isolate HIPAA as the primary cause for certain changes in health insurance coverage or cost. There have been some changes, however, in which it appears, based on our review of available data and on our discussions with interested parties, that HIPAA has been a factor.

In the area of healthcare and health insurance costs, there have been significant increases in recent years. While these increases affect all consumers of healthcare, our research shows that the increases have been larger for small employers who are more affected by the guaranteed issue and pre-existing conditions limitations provisions of HIPAA.

In response to the increasing cost of health insurance, insurers, frequently responding to employers' needs to control costs, have been modifying benefit plans. These modifications include such features as increases in copays and deductibles, particularly in the area of pharmaceutical coverage. These changes appear to be more prevalent in the small group area. In addition, there have been some actions by insurers that could limit the extent of small group coverage. These actions range from changes in commission structure to actually leaving the small group market.

One of the goals of HIPAA was to reduce job immobility due to health coverage as healthcare portability is one of many factors that could affect job lock. While it is extremely difficult to isolate lack of healthcare portability from other causes of job lock, there are some study results that indicate that lack of healthcare portability, as a cause for job-lock, appears to be declining.

Appendix 1: Department of Insurance Question Set

The Andersen Team is working to provide services to the Private Health Insurance Group of the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration) to determine the effects of the eligibility components of HIPAA Title I in five sample states: Colorado, Illinois, Missouri, North Carolina and Texas. Since we initially interviewed insurance regulators and healthcare payers in the spring of 2001, the scope of our yearlong project has narrowed.

Although HIPAA's provisions were intended to be positive influences on healthcare portability and availability, our revised scope involves attempting to determine any negative changes in the healthcare market resulting from this legislation. The following questions are designed to determine HIPAA's impact on benefit packages offered by health plans, employer waiting periods, and alleviation of job-lock (the phenomenon that workers fear changing jobs because they may lose or reduce their health benefits).

We would appreciate your assistance in providing answers to these questions as well as providing information on any other areas in which HIPAA has had an impact on the healthcare market.

Health Plans

1. Have benefit plans offered by health insurers changed as a result of HIPAA's limitations on pre-existing condition exclusions?
2. What changes to benefit structures, i.e. limited benefit packages or imposed benefit restrictions, have been made as a result of pre-exiting condition exclusions by HIPAA?
3. What markets are affected by these changes, i.e. Individual, Small Group, and Large Group?
4. What plans are affected by these changes, i.e. HMO, PPO, indemnity, etc?
5. Have there been any trends in violations or complaints regarding health plans since HIPAA was implemented?

Employers

1. How have the provisions of HIPAA impacted employer waiting periods for employee health coverage?
2. What other steps have employers taken to restrict employee health coverage as a result of HIPAA provisions?
3. What data does the DOI have/collect that will enable us to draw conclusions about changes in employer waiting periods related to HIPAA?

4. Faced with rising health costs and liability risks, what other types of plans have employers considered shifting to that would allow employees to choose their own health insurance arrangements?
5. Have there been any trends in violations or complaints in employer-sponsored health coverage since HIPAA was implemented?

Job-Lock

1. Are there any state continuation of coverage laws that could affect employee job-lock or encourage early retirement?
2. Have any of the provisions of HIPAA helped to alleviate job-lock?
3. Do you have quantitative information or resources for information related to job-lock?

Appendix 2: Healthcare Payer Question Set

An Andersen team is working to provide services to the Private Health Insurance Group of the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration) to determine the effects of the eligibility components of HIPAA Title I in five sample states, including Colorado, Illinois, Missouri, North Carolina and Texas. Since we initially interviewed insurance regulators and health care payers in the Spring of 2001, the scope of our yearlong project has narrowed.

Although HIPAA's provisions were intended to be positive influences on healthcare portability and availability, our revised scope involves attempting to determine any negative changes in the healthcare market resulting from this legislation. The following questions are designed to determine HIPAA's impact on benefit packages offered by health plans.

We would appreciate your assistance in providing answers to these questions as well as providing information on any other areas in which HIPAA has had an impact on the healthcare market.

1. Have benefit plans offered by health insurers changed as a result of HIPAA's limitations on pre-existing condition exclusions?

2. What changes to benefit structures have been made as a result of pre-existing condition exclusions by HIPAA?

3. What markets are affected by these changes, i.e. Individual, Small Group, and Large Group?

4. What plans are affected by these changes, i.e. HMO, PPO, indemnity, etc?

5. What trends exist among health insurers that have altered employer sponsored benefit plans due to HIPAA?

Appendix 3: Large Employer Survey

HIPAA Title I Impact Survey

Organization Name: _____
Interviewee(s): _____
Title: _____
Telephone/Fax No.: _____
E-mail: _____

An Andersen Team is working to provide services to the Private Health Insurance Group of the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration) to determine the effects of the eligibility components of HIPAA Title I (implemented in 1997) in five sample states: Colorado, Illinois, Missouri, North Carolina and Texas.

As HIPAA's provisions were intended to be positive influences on healthcare portability and availability, we are attempting to determine any negative changes in the healthcare market resulting from this legislation. The survey consists of 21 questions and will take approximately one-half hour to complete. The survey will cover a variety of topics, with emphasis in the areas of Employer-Sponsored Health Coverage, Health Plan Changes, and Job Lock. The questions are designed to determine HIPAA's impact on employer waiting periods, benefit packages offered by health plans, and alleviation of job-lock (the phenomenon that workers fear changing jobs because they may lose or reduce their health benefits).

Your organization has been selected as one of the ten premier employers in your state. Each organization was chosen to receive the survey based on prestige, physical presence and utilization of best practices. Your participation in this survey and the information you provide is very valuable to us. In return for participating in this survey, you will receive a summary of the survey results for your state. This summary will include useful statistics and trends that will provide you with an opportunity to benchmark your organization against the other premier organizations participating from your state. The findings will be mailed to you at the end of October. Participating organizations will not be identified by name in any of our reports.

We would appreciate your assistance in providing informative responses to these questions as well as providing information on any other areas in which HIPAA has had an impact on your employer-sponsored health plan. If you have any questions please contact Shana G. Lawlor (202) 481-3553.

Please email the completed survey to shana.g.lawlor@us.andersen.com or fax to (202) 481-3700 by Monday, October 1st.

Employer-sponsored Health Coverage

1. *Is your company fully-insured or self-insured for health coverage?* (check one below)

   ___*Fully-insured* ___*Self-insured*

2. *How many employees does your company have?* _____

3. *What percentage of employees is accepting health coverage through your company?*

_____
_____
_____

4. *Have the provisions of HIPAA impacted the waiting period your company offers for employee health coverage?*

(Check one) ___*Yes* ___*No*

If yes, please explain below:

_____
_____
_____

5. *Since the implementation of HIPAA, has your company made changes in benefit plans and/or cost-sharing arrangements to the following:*

___Deductibles ___Copays
___Coinsurance ___Other: _____

_____
_____
_____

6. *Has your company made changes to employer premium contributions for health benefits since 1997?*

(Check one) ___*Yes* ___*No*

If yes, are these changes a direct result of HIPAA provisions?

(Check one) ___*Yes* ___*No*

(Please explain below)

_____
_____
_____

7. *What other steps has your company taken with eligibility provisions for health coverage as a result of HIPAA's provisions?*

   ___Tightened definition of full-time

   ___Changed "actively-at-work" provision

   ___Other: _____

   (Please expand below)

   _____
   _____
   _____

8. *If your company is currently fully-insured for health coverage, have you considered changing to self-insured status?*

   (Check one)___Yes ___No

   If yes, under what circumstances would your company make this change?
   (Please explain below)

   _____
   _____
   _____

9. *Faced with rising health costs and liability risks, what other types of health plans has your company considered shifting to that would allow employees to choose their own health insurance arrangements?*

   ___Cafeteria Plans with Flexible Spending Accounts
   ___Defined Contribution
   ___Other: _____

   (Please expand below)

   _____
   _____

Health Plan Changes

1. *What changes in benefit plans has your health carrier made since the implementation of HIPAA?*
   (e.g. additional limits on coverage, changes in benefits offered)

   (Please explain below)

   _____

_____

_____

2. *Has your company had one or more of your health carriers withdraw from the marketplace since the implementation of HIPAA?*

(Check one) ___*Yes* ___*No*

If yes, did your company have difficulty finding a replacement health carrier?

(Check one) ___*Yes* ___*No*

Job Lock

1. *What education on continuation of health coverage does you company provide exiting employees?* (Please explain below)

_____

_____

2. *Does your company perform calculations for voluntary employee turnover?*

(Check one) ___*Yes* ___*No*

If yes, do these statistics show that portability laws are alleviating the problem of job-lock?

(Check one) ___*Yes* ___*No*

Please provide information on voluntary turnover rates that your company is using to make this determination.

_____

_____

_____

3. *Does your company track voluntary turnover rates by demographics?*

(Check one) ___*Yes* ___*No*

If yes, please provide voluntary turnover rates by percentage below:

Ethnicity:

___Hispanic ___African-American
___Asian ___Caucasian
___Pacific Islander ___Other: _____
___Native American

Gender:
___Female
___Male

Age:
Please indicate categories used for tracking age statistics within your company along with voluntary turnover percentages.

%	*Category*	%	*Category*
___	_____	___	_____
___	_____	___	_____

4. *According to exit interviews, how satisfied are employees with company health insurance?*

   Check your answer using the scale below:

Very Unsatisfied	**Slightly Unsatisfied**	**Somewhat Satisfied**	**Slightly Satisfied**	**Very Unsatisfied**
1	**2**	**3**	**4**	**5**

5. *Has your company seen a change in the reasons employees site for voluntarily leaving their place of employment prior to and post HIPAA?*

   (Check one) ___*Yes* ___*No*

   What trends can your company identify for employees leaving their employment (e.g. lack of specific benefits – elder care etc.)?

   (Please explain below)

   _____
   _____
   _____

6. *Are workers declining or dismissing job opportunities and remaining in their current position in order to retain health benefits?*

Check your answer using the scale below:

Very Unsatisfied	Slightly Unsatisfied	Somewhat Satisfied	Slightly Satisfied	Very Unsatisfied
1	2	3	4	5

7. *Are there differences in health insurance coverage for part-time workers vs. full-time workers within your company?*

(Check one) ___*Yes* ___*No*

8. *Do you track productivity rates?*

(Check one) ___*Yes* ___*No*

If yes, are you able to determine if productivity rates are linked to employee job-lock?

(Check one) ___*Yes* ___*No*

Please provide information that your company is using to make this determination

_____

_____

_____

9. *Are part-time employees switching to full-time work to gain health insurance coverage?*

Check your answer using the scale below:

Very Unsatisfied	Slightly Unsatisfied	Somewhat Satisfied	Slightly Satisfied	Very Unsatisfied
1	2	3	4	5

10. *Does your company offer additional benefits such as flex-time/telecommuting, day care, or elder care services as a way to encourage full-time vs. part-time work schedules?*

    *(*Please explain below)

    _____

    _____

    _____

Conclusion

- This concludes our survey. Thank you for taking the time to complete the survey. Do you have any questions?

- As I review the information I have collected from you, I may have a few questions. May I call or email you again to clarify information or fill gaps in my knowledge?

- In return for you participation in this survey, we will e-mail you a summary of the trends we have found when it is complete. May I have your e-mail address?

EMAIL ADDRESS:

If you have any questions, please feel free to call Shana G. Lawlor at (202) 481-3553. Fax (202) 481-3700.

Appendix 4: Small Employer Advocacy Group Question Set

An Andersen team is working to provide services to the Private Health Insurance Group of the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration) to determine the effects of the eligibility components of HIPAA Title I in five sample states, including Colorado, Illinois, Missouri, North Carolina and Texas.

As HIPAA's provisions were intended to be positive influences on healthcare portability and availability, we are attempting to determine any negative changes in the healthcare market resulting from this legislation. We are currently interviewing the various stakeholders of HIPAA and other similar legislation (i.e. guaranteed issue provisions), including Departments of Insurance, healthcare payers and large/small employers.

We feel that small business advocacy groups will be able to provide us with a unified perspective for all small businesses in the sample states. The following questions are designed to determine HIPAA's impact on benefit packages offered by health plans, employer waiting periods, and alleviation of job-lock (the phenomenon that workers fear changing jobs because they may lose or reduce their health benefits).

1) How has HIPAA affected employer premium contributions for employee coverage?
2) How has HIPAA affected employer waiting periods for coverage?
3) How has HIPAA affected benefit packages offered by health plans to employers?
4) What changes have occurred post-HIPAA in employer elections regarding cost-sharing levels for benefit packages (i.e. levels of deductible, copay, and coinsurance)?
5) How has HIPAA alleviated job-lock (the phenomenon that workers fear changing jobs because they may lose or reduce their health benefits)?
6) Has there been a change since HIPAA in the number of employers changing from fully-insured status to self-insured status?

We would appreciate your assistance in providing answers to these questions as well as providing information on any other areas in which HIPAA has had an impact on the small businesses.

Appendix 5: Reference Documents for Job Lock Information

The Andersen Team analyzed human resource literature and related job-lock documents to research the issue of job immobility related to health coverage. This appendix lists the various sources that were of most value in developing the methodology for our analysis. These sources can be accessed through the hyperlinks provided. Following the tables are brief summaries of some of the resources used in the development of the job lock discussion of Report #4.

Human Resource Literature

Source	Document
American Management Association	Compensation and Benefits: A Focus on Gender, May 1999 Not available online
International Personnel Management Association	Top Trends in Resource Management http://www.ipma-hr.org/public/research_template.cfm?ID=3
International Personnel Management Association	Turnover Tallies http://www.ipma-hr.org/public/pubs_template.cfm?ID=34
Society for Human Resource Management	2000 Retention Practices Survey Only available to members

Surveys and Reports

Source	Document
Center for Policy Research, Syracuse University	Working Paper No 19; Chronic Illness and Health Insurance-Related Job Lock, March 2000, Revised August 2000 http://www-cpr.maxwell.syr.edu/cprwps/pdf/wp19.pdf
Employee Benefit Research Institute	Health Confidence Survey, 1998 http://www.ebri.org/hcs/1998/index.html Health Confidence Survey, 2001 http://www.ebri.org/hcs/2001/index.html
Federal Reserve Bank of San Francisco, Economic Letter	Health Insurance and the U.S. Labor Market, April 17, 1998 http://www.frbsf.org/econrsrch/wklyltr/wklyltr98/el98-12.html
Jerome Levy Economics Institute of Bard College	Job lock: An Impediment to Labor Mobility? Is Health Insurance Crippling the Labor Market? http://www.levy.org/docs/ppb/ppb10.pdf

Source	Document
U.S Department of Labor, Bureau of Labor Statistics	Earnings and benefits of contingent and noncontingent workers http://stats.bls.gov/opub/mlr/1996/10/art3full.pdf
U.S Department of Labor, Bureau of Labor Statistics	Employee Benefits in Small Private Industry Establishments http://www.bls.gov/ncs/ebs/sp/ebnr0004.pdf
U.S Department of Labor, Bureau of Labor Statistics	Employee Benefits in Medium and Large Private Establishments http://www.bls.gov/ncs/ebs/sp/ebnr0005.pdf
U.S Department of Labor, Bureau of Labor Statistics	National Longitudinal Surveys: Discussion Paper - An Analysis of the Consequences of Employer Linked Health Insurance Coverage in the United States, December 1995 http://www.bls.gov/ore/abstract/nl/nl950100.htm

Brief Summaries

Society for Human Resource Management
2000 Retention Practices Survey

This document is a summary of survey results conducted to "gather information on retention challenges and strategies in today's workplace." The document presents findings from survey responses of 473 human resource professionals and offers recommendations for improving retention in the workplace, including the use of health benefits as a competitive tool. The survey reports findings on the number of voluntary resignations from 1997 to 2000, concluding that organizations with more than 1,000 employees were the most affected by voluntary employee turnover. Better benefit packages from a potential employer were cited as one of the top two reasons why employees pursued employment elsewhere. Therefore, benefit packages are considered one of the top three most effective retention tools.

Center for Policy Research
Working Paper No. 19
Chronic Illness and Health Insurance – Related Job lock
http://www-cpr.maxwell.syr.edu/cprwps/pdf/wp19.pdf

This study is based on the premise that workers who have high medical expenses due to chronic illness are most susceptible to insurance-related job lock. The study focuses on Indiana workers who themselves or a family member faced a chronic or prolonged medical condition in 1994.

The paper states that previous studies do not address workers with chronic illness. According to the authors, statistics on persons with serious illness do not appear in large surveys such as the Panel Study of Income Dynamics (PSID), the Survey of Income and Program Participation (SIPP) and the National Medical Expenditure Survey (NMES). Therefore, the analyses of these surveys do not realize the impact of job lock on persons with serious/chronic illness.

The Center for Policy Research states that their study results "identify previously under-appreciated job lock among chronically ill workers and workers with a chronically ill family member, clarify how one best researches job lock, and indicate the potential impact of policies aimed at alleviating job lock and promoting inter-employer worker mobility."

The Jerome Levy Economics Institute of Bard College
Public Policy Brief
Job lock: An Impediment to Labor Mobility
http://www.levy.org/docs/ppb/ppb10.pdf

This policy brief discusses employer-provided health insurance as it relates to labor mobility and seeks to address the existence of job lock. The Institute states that, "If job lock is a real phenomenon, the nation pays an economic price in terms of the costs associated with the misallocation of workers among productive opportunities; higher relocation and training costs for those workers who have stayed too long in their jobs; and the loss of innovation, employment and competition related to start-up ventures."

The study uses data collected from the Panel Study of Income Dynamics (PSID) and accounts for certain characteristics of workers, including marital status, work status of spouse, income level, age, job tenure and entrepreneurship. Some of the study's initial findings are:

- Employees with employer-provided health insurance are less likely to change jobs than those without insurance.
- There is no statistically distinguishable difference in mobility rates among those whose spouses have insurance coverage and those whose spouses do not.
- Job mobility rates are not significantly influenced by income level or age.
- Those employees with less than three years job tenure seem to have more concerns about job lock than employees with longer job tenure.
- An individual's decision to become self-employed does not appear to be negatively influenced by the presence or lack of health insurance.

U.S Department of Labor, Bureau of Labor Statistics
National Longitude Surveys: Discussion Paper
An Analysis of the Consequences of Employer Linked Health Insurance Coverage in the United States
http://www.bls.gov/ore/abstract/nl/nl950100.htm

This paper offers critiques of arguments and evidence presented in existing job lock studies, stating that existing studies make assumptions that are counterfactual. Specifically the author discusses the limited view in some studies, which relate health coverage and mobility, that an individual's employment decisions do not affect health insurance coverage status. According to the author, employment experience and the frequency of an individual's job changes are two characteristics of an individual's labor supply, which affect health insurance status. Additionally, the author states that existing job lock studies do not account for "individual preferences and other unobservable differences among individuals which may affect both the frequency of job changes and health insurance coverage status."

The paper presents a new model for studying job changes and health insurance coverage that considers the following three questions:

1. What factors determine changes in individual's health insurance coverage over time?
2. How do increases in the price of health insurance coverage affect an individual's job mobility and health insurance coverage status?
3. How does an individual's propensity for job mobility affect the probability that he will have a job that offers health insurance coverage?

The paper applies National Longitudinal Survey of Youth (NLSY) data to the model to produce the following results:

- An equation to describe the circumstances under which an individual's level of demand for healthcare will deter him from changing jobs;
- Increases in the employer cost of providing health insurance coverage to employees will have a significant and negative effect on job mobility; and
- An individual's propensity to change jobs is negatively correlated to the probability the individual will receive health insurance coverage from an employer.